have been somewhat rearranged, with nothing omitted, in order to accomplish an economy of space; the additional pages thus made available will be used for the publication of additional scientific material.

Together with a change in binding made several months ago and a change in paper stock made last month, the new format of this issue brings into complete being a program of publication economy long discussed and recently agreed upon by the Council of the Association. It is hoped that this program will make the pages of CALIFORNIA AND WESTERN MEDICINE even more valuable to its readers than in the past, and at the same time will accomplish monetary economies that will be reflected in the Association's financial statements.

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Editorial Board for "California and Western Medicine."—At Del Monte, the Council appointed an Editorial Board to whose members will be referred annual session manuscripts. The executive committee of the Board will coöperate with the Editor and Committee on Publications. (See June issue, on page 351.) The representatives of the specialty groups who are members of the Editorial Board are as follows:

Chairman of the Board:
George D. Barnett

Executive Committee:
Sumner Everingham, Oakland, Chairman.
Mast Wolfson, Monterey.
Albert J. Scholl, Los Angeles.
George W. Walker, Fresno.
Chauncey D. Leake, San Francisco.

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Charles F. McCuskey, Glendale.
H. R. Hathaway, San Francisco.

Dermatology and Syphilology:
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William H. Goeckerman, Los Angeles.

Eye, Ear, Nose, and Throat:
Frederick C. Cordes, San Francisco.
L. G. Hunnicutt, Pasadena.
George W. Walker, Fresno.

General Medicine:
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George H. Houck, Los Angeles.
Mast Wolfson, Monterey.

General Surgery (including Orthopedics):
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Industrial Medicine and Surgery:
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Delos Packard Thurber, Los Angeles.

Plastic Surgery:
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William S. Kiskadden, Los Angeles.

Neuropsychiatry:
John B. Doyle, Los Angeles.
Olga Bridgman, San Francisco.

Obstetrics and Gynecology:
Erle Henriksen, Los Angeles.
Daniel G. Morton, San Francisco.

Pediatrics:
William A. Reilly, San Francisco.
William W. Belford, San Diego.

Pathology and Bacteriology:
David A. Wood, San Francisco.
R. J. Pickard, San Diego.

Radiology:
R. R. Newell, San Francisco.
Henry J. Ullmann, Santa Barbara.

Urology:
Lewis Michelson, San Francisco.
Albert J. Scholl, Los Angeles.

Pharmacology:
Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 37.

EDITORIAL COMMENT†

NEOPLASTIGENIC SENSITIVITY

The development of technical methods for the study of "latent neoplasms" or "subthreshold neoplastic states," is currently reported by Rous,[1] Kidd and MacKenzie,[2] of the Rockefeller Institute.

When a carcinogenic agent is applied to mammalian skin it nearly always elicits preliminary benign growths. These precancerous states have thus far received relatively little attention, due largely to the fact that in the mouse, the commonest experimental animal, the initial "warts" are prone to become malignant very soon. In rabbits, however, the initial neoplasms retain their benign character for long periods of time,[3] only a small percentage of them becoming malignant after months or years of repeated tarring. If the tarring is interrupted in the benign stage, the growths almost invariably dwindle and disappear, the skin being restored to apparently normal. About ten years ago, however, it was shown by des Ligneris[4] of South Africa, that this restoration is physiologically incomplete, the apparently normal skin remaining for many months hypersusceptible to tar. On reapplication of tar there is an explosive response, new warts often appearing within 10 days as contrasted with the 5 months tarring required in normal controls. This acquired neoplastigenic allergy or hypersusceptibility is described by Rous and his coworkers

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Rous, P., and Kidd, J. G.: Jour. Exper. Med., 7:365 (Mar.), 1941.

2 MacKenzie, I., and Rous, P.: Jour. Exper. Med., 73:391 (Mar.), 1941.

3 Rous, P., and Kidd, J. G.: Jour. Exper. Med., 69:399, 1939.

4 des Ligneris, M. J. A., Annual Report of the South African Institute for Medical Research, 1930, 1.

as a "subthreshold neoplastic state," or heightened "neoplastic potentiality." In his hands carcinohypersensitive skin will respond equally well to nonspecific irritants. Explosive wart formation, for example, follows the application of such noncarcinogenic agents as acetone or turpentine or as a result of local mechanical trauma or wound healing.

By repeatedly tarring of rabbit skin throughout a period less than that required to elicit macroscopical growths, the Rockefeller Institute oncologists showed that "many more cells are rendered potentially neoplastic than ever assert themselves in tumor formation under ordinary experimental conditions." After a rest period of six or more months, the treated skin may respond to local mechanical trauma (wound healing) by explosive neoplastic growths. This observation is in line with the popular belief that trauma may lead to local cancer. Demonstration that a previous carcinogenic sensitization is necessary for the development of such "traumatic cancers," however, is a new observation, which eventually may prove to be of basic clinical interest. The essential cause of the presumptive "traumatic cancer" may well have been a virus or other carcinogenic agent, which "may have done its work years before and the cells it rendered neoplastic [may have] remained ever since within their morphological context, incapable of asserting themselves until some intercurrent accident—a blow, a wound, a burn—stirs them to proliferation." The medicolegal bearing of this synergic theory is obvious.

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SKIING INJURIES

During the past season of skiing in the Sugar Bowl area, near Norden, California, 153 persons received first-aid for accidental injuries sustained while skiing. This service was provided by members of the Sugar Bowl Ski Club, expert skiers who are trained in first-aid performance under the difficult conditions of snow-covered, mountainous terrain.

Of these 153 cases, there were thirty simple fractures of the tibia or fibula, or both bones together, and two fractures of fingers. Other serious injuries included three dislocations of the shoulder joint, and seventy-six sprains of the ankle or knee joint of varying degrees of severity. The remaining thirty-two cases suffered from cuts, puncture wounds, contusions and abrasions sufficiently painful to lead the victim to apply for treatment.

It is difficult to count accurately the skiers who are using the slopes of this region, but estimating their number from reports of the transportation services to and from the Sugar Bowl area, the incidence of injury is found to be about 1 per cent. This probably represents the highest accident rate of any American sport.

In spite of study by the National Park Service, various ski clubs, and other interested organizations, very little has been accomplished toward reducing the hazards of skiing. With the increasing popularity of this sport, a steady rise in the number of resulting injuries must be expected, and facilities provided minimizing their harmful results.

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PREVENTION OF FLAT FEET

The human foot is not a perfectly adapted structure. Evidence points to the fact that a pronated foot is more likely to give rise to pain on prolonged standing or walking than is a supinated foot. When mild varus (inversion) deformity gives rise to pain, it does so principally as the result of callus formation on the lateral aspect of the foot. It does not, however, cause severe aching pain that a reverse deformity of valgus (flat foot) of equal severity may cause. On weight bearing, the normal foot is constantly being thrust into a position of valgus or pronation.

Few will deny that the therapy of pronated feet is not satisfactory. This is evidenced by the multiplicity of methods of treating pes valgus. Many of the methods, indeed, are based on diametrically opposite principles. For instance, Blundell Bankhart believes the longitudinal arch of the foot in an individual with painful pes valgus should be flattened completely. Most authorities believe that every effort should be made to increase the height of the longitudinal arch by the use of arch supports or shoe corrections.

Can flat feet be prevented? Most prophylactic measures for pes valgus are performed on children from three to thirteen years of age. But is this not too late to start prevention? The Chinese, when they wished to reshape a foot into the type they considered beautiful, started binding the feet at an early age. We do not wait to correct an obvious club-foot (equino varus) until the child is three, but we prefer to start shortly after birth.

It seems to me that it would be desirable to strap all infants' feet with adhesive tape into a position of varus a few days after birth. The obstetrician and pediatrician could do this just as easily as they prescribe formulae for infant feeding. Strapping could be continued for a period of one month. The resultant atrophy of the leg musculature would be negligible. Another objection that might be raised to this procedure is that the new-born's foot is normally slightly inverted. However, this inversion disappears within one week after birth, leaving the infant's foot in valgus (flat foot) position.

By inauguration of such a program, we should at least be more prone to recognize and treat infants with obvious or mild valgus deformities at an earlier age. Our army, in later years, might then not be depleted by so many men complaining of "flat feet."

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